Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046023	A. BUILDING _____ B. WING _____	C 09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CEN	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represents the findings of complaint investigation KS#59494.	S 000		
S 340 SS=D	28-39-152 QUALITY OF CARE Quality of care. Each resident shall receive and the nursing facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and the plan of care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included 3 residents. Based on observation, record review and staff interview, the facility failed to provide necessary care and services in accordance with the comprehensive assessment and the individualized plan of care for 1 (#1) of 3 residents sampled. Findings included: - Resident #1's quarterly Minimum Data Set (MDS) dated 8/28/12 recorded a Brief Interview for Mental Status of 7 which indicated severe cognitive impairment. The MDS further indicated that the resident was independent with bed mobility, transfer, walking, dressing, personal hygiene, and required supervision with eating and bathing, and recorded no behaviors exhibited. An Elopement Risk Assessment dated 6/4/12 noted that the resident was cognitively impaired, ambulatory, had poor decision making, history of elopement, and the ability to exit the facility.	S 340		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046023	A. BUILDING _____ B. WING _____	C 09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CEN	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 340	Continued From page 1 The resident's care plan dated 6/21/11 noted the resident was at risk for elopement and wandering due to the resident was without regards to, and was oblivious to, safety. The staff placed a room and door identifier to assist the resident with locating room, staff should be aware of resident's location at all times, offer diversion activities, social services available to assist with change and adjustment, current picture available, would wear wanderguard, and staff to monitor wanderguard placement and functioning every shift. Nurse's note dated 8/12/12 documented at 2:30 P.M. that at 9:12 A.M. the resident was noticed to be out of his/her room and nowhere in the building after finding out that one of the facility's doors was not locked. Resident's name was paged out 3 times demanding him/her to come back to the room with no success. 10 minutes prior to the incident the resident was seen in the dining room sitting down reading newspaper. After 5-10 minutes resident was found outside the building walking towards the door that was open. Resident verbalized that he/she went outside for a walk to get some fresh air. Skin assessment done, no injuries noted, denies pain or discomfort. Responsible party called, physician notified, no new orders, facility management notified of elopement, resident currently moved to Special Care Unit temporarily. Code alert bracelet present on left leg and functioning. The facility's report documented that staff found the resident about 75 feet from the door he/she had exited from and was heading back toward the facility. An observation of the resident on 9/13/12 at 10:20 A.M. noted the resident laid on his/her bed	S 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046023	A. BUILDING _____ B. WING _____	C 09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CEN	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 340	Continued From page 2 with wanderguard in place. An observation of the resident on 9/13/12 at 11:40 A.M. noted the resident seated in the dayroom with the wanderguard in place. An interview with Administrative staff A on 9/13/12 at 9:00 A.M. indicated that resident #1 had exited the facility through an unlocked exit door on unit 1 north which additionally did not have a wanderguard alarm in place. An interview with licensed nursing staff B on 9/13/12 at 12:30 P.M. noted that wanderguard placement and function was checked on every shift. He/she further initially stated that if the electricity to the facility goes off, exit doors are disarmed and staff should monitor the doors. At 12:52 P.M. licensed staff A stated that he/she had inquired and had been informed that in the case of electrical outage the exit doors re-alarm within 3 seconds of the generator turning on. An interview with licensed nursing staff C on 9/13/12 at 12:25 P.M. noted that he/she was uncertain how often the placement and function of wanderguards were checked. An interview with licensed nursing staff D 9/13 at 12:25 P.M. stated that wanderguards were checked for placement and function every shift and documented in the treatment book. An interview with resident #1 on 9/13/12 at 12:35 P.M. indicated he/she had no recollection of the elopement. The facility failed to provide adequate supervision for this cognitively impaired, dependent resident	S 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046023	A. BUILDING _____ B. WING _____	C 09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CEN	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 340	Continued From page 3 who was at risk for elopement.	S 340		
S1174 SS=F	26-40-303 (2)(a)(i)(ii)(iii) P E - Door monitoring system (2) Door monitoring system. The nursing facility shall have an electrical monitoring system on each door that exits the nursing facility and is available to residents. The monitoring system shall alert staff when the door has been opened by a resident who should not leave the nursing facility unless accompanied by staff or other responsible person. (A) Each door to the following areas that is available to residents shall be electronically monitored: (i) The exterior of the nursing facility, including enclosed outdoor areas; (ii) interior doors of the nursing facility that open into another type of adult care home if the exit doors from that adult care home are not monitored; and (iii) any area of the building that is not licensed as an adult care home. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The facility identified 2 cognitively impaired and independently mobile residents on the unlocked unit and 17 cognitively impaired and independently mobile residents of the Special Care Unit (SCU). Based on observation, record review and staff interview, the facility failed to provide an electrical monitoring system on every door that exits the facility and was accessible to	S1174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046023	A. BUILDING _____ B. WING _____	C 09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CEN	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1174	Continued From page 4 residents. Findings included: - An observation during initial tour of the facility accompanied by Administrative staff A on 9/13/12 at 9:15 A.M. noted the exit door of the lower floor lodged open with no staff observed. Construction staff then appeared and stated that he/she had left the door lodged open. An observation on 9/13/13 at 12:49 P.M. noted the door in the open position until 12:52 P.M. During this time licensed nursing staff B walked past the open elevator door without taking any action. An observation on 9/13/12 at 2:00 P.M. accompanied by administrative staff A noted the alarm to the exit door in the SCU to be disarmed. Administrative staff A noted that resident's had recently been taken out the door to smoke. An observation on 9/13/12 at 2:15 P.M. accompanied by administrative staff A and consultant staff E noted that the exit door to the parking of the lower unit, and the main entrance/exit door of the upper floor of the facility did not have alarms. An interview with licensed nursing staff B on 9/13/12 at 12:30 P.M. stated that if the electricity to the facility goes off, exit doors are disarmed and staff were to monitor the doors. At 12:52 licensed staff A advised that he/she had inquired and had been informed that in the case of electrical outage the exit doors re-alarm within 3 seconds of the generator turning on. The facility failed to ensure all exits doors of the	S1174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046023	A. BUILDING _____ B. WING _____	C 09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CEN	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1174	Continued From page 5 facility were electrically monitored.	S1174		